

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

AVONEX (interferon-beta 1A)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext. and options _____ Fax# _____

Pharmacy _____ Pharmacy Phone#: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY**

CRITERIA:

- ▶ **DOCUMENTED** diagnosis of Multiple Sclerosis

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Telephone request from physician or pharmacy

1 year